North Carolina Department of Health and Human Services
Michael F. Easley, Governor
Dempsey Benton, Secretary

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July 7, 2008

MEMORANDUM

TO:
Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: William W. Lawrence, Jr., MD
Leza Wainwright

SUBJECT: Implementation Update #45
Accreditation Update
Community Support 25% Requirement
Community Support Suspension
Service Definition Workgroup Update
CAP-MR/DD Update
PCP Change for Court Involved Consumers
Staffing Announcements from DMA
Reporting Provider Changes
Common Billing Errors
New Denial Code on EOB
NEA Forms

Accreditation Update

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and Local Management Entities (LMEs) continue to monitor the progress of providers toward achieving national accreditation. Most of the enhanced services require providers of those services to achieve national accreditation within three years of enrollment with the Division of Medical Assistance (DMA) as a service provider.

In Implementation Update #39 (February 6, 2008), the latest dates possible for a provider to initiate the accreditation process in order to obtain accreditation by March 20, 2009 were identified by the four accreditation agencies. As of this writing, the date for one of those accreditation agencies, COA, has past. The next, CARF, is fast approaching with a cut off date of July 31, 2008.

The LMEs are tasked with receiving updates from the providers in their catchment areas according to the schedule identified in Implementation Update #42 (April 7, 2008). Per this schedule, as of May 31, 2008, the providers who were enrolled to provide community intervention services in March of 2006 should have informed the LMEs of the selection of an accreditation agency. The schedule also requires that by July 31, 2008, the provider will have presented evidence to the LME that the provider has entered into a formal agreement to engage the accreditation agency of its choice. That evidence

is a letter or other formal communication from the accreditation agency that the transaction is official. DMH/DD/SAS is also in communication with the accreditation agencies, and has received from them the templates or other forms which they normally use for this formal communication.

In addition, the accreditation agencies regularly provide to DMH/DD/SAS the lists of those agencies with which they have established formal relationships. Based on the most recent update of those submissions to DMH/DD/SAS by the accreditation agencies:

- Number of site and service specific enrollment numbers which were installed between March 1, 2006 and May 1, 2006: 1639
- Number of individuals agencies represented by this number (from IRS numbers): 473
- Number of agencies which are accredited: 50 (10.6%)
- Number of agencies in process of being accredited: 131 (27.7%)
- Number of agencies not yet officially identified by an accrediting agency: 292 (61.7%)

As we progress toward the March 20, 2009 deadline, the interim timelines established in Implementation Update #39 will require close oversight and appropriate action by the DMH/DD/SAS and the LMEs. Contingencies identified in these timelines are put in place to assure that persons served by agencies that will not achieve accreditation by the deadline will not experience disruptions in their services.

Community Support 25% Requirement

We have heard from providers expressing concern about the methodology outlined in Implementation Update #44 for monitoring providers' compliance with the requirement that 25% of all billable Community Support Services must be delivered by a Qualified Professional (QP). The primary concern providers identified was the potential that by the time a provider recognizes or is notified by the Local Management Entity (LME) that they have failed to meet the 25% requirement in any given month based upon paid claims data, there may be a limited number of check write cycles left in the subsequent month to improve performance. In order to address these concerns, we are making the following modifications in the policy which constitutes an amendment to the Policy and Procedures for Endorsement of Providers of Medicaid Reimbursable MH/DD/SA services.

- Compliance with the 25% QP requirement will continue to be monitored using paid claims data. This is the most timely, accurate, and consistent data available.
- Compliance will continue to be measured separately for Child and Adult Community Support since they are separate services.
- Compliance will continue to be monitored separately by funding source – Medicaid or DMH/DD/SAS funds.
- Compliance will continue to be measured separately for each Community Support provider number – site specific.
- Compliance will be measured over a "rolling" three month period of time. LMEs will review compliance of all providers on a monthly basis and notify providers that are not in compliance with the 25% QP requirement in any given month. For the purpose of continued enrollment in the Medicaid program or continued ability to contract for state funded services, however, the compliance requirement will be that 25% in aggregate of all paid claims over the most recent three month period must meet the QP requirement. For example:
    - LMEs began monitoring compliance with the requirement beginning with paid claims for the month of May, 2008, based upon claims paid for dates of service in March 2008 or later (the effective date of the new policy). They have notified providers who did not meet the requirement in May. They will review paid claims for the month of June and will again notify providers whose paid claims did not meet the threshold, <u>but will take no endorsement or contract action at that time</u>. When they receive paid claims for the month of July, they will review the July payments discreetly and notify providers who have not met the requirement in July, and will also total all of the units of Community Support Child and/or Community Support Adult (separately, by service and funding source) for the three month period for the provider to determine if the 25% requirement was met in total over those three months. The provider's endorsement to provide a Medicaid service or state-funded contract will be withdrawn if the provider did not meet the requirement over the three month period.
    - When the LME receives paid claims for the month of August, 2008, they will perform the review for the individual month, as well as in total for the months of June, July, and August. When September paid claims are received, they will be reviewed for the individual month and will be totaled with payments from the months of July and August, and so forth throughout the year.
- If a provider's endorsement to provide a Medicaid service or state funded contract is withdrawn as a result of the paid claims data failing to document compliance with the 25% QP requirement over any given three month period, the provider may request reconsideration by the LME if the provider contends that they actually met the requirement based upon billable services delivered. In this case, the burden of proof is on the provider to

document the billable services delivered and to explain why they believe the paid claims data does not reflect that fact.

- If a provider's endorsement to provide a Medicaid service is to be withdrawn as a result of failure to comply with the 25% QP requirements, the endorsement action – as documented in the Notification of Endorsement Action (NEA) letter – will become effective on the first of the second month following the month in which the LME documents the failure to comply. For example, the LME determines in August that the provider failed to meet the compliance requirements over the months of May, June and July. The NEA withdrawing endorsement will be dated October 1. That will allow the provider and LME approximately 45 days to transition consumers to other providers before the provider that failed to meet the requirement is terminated from the Medicaid program.

We believe that this change in process is responsive to the concerns that providers have expressed and also continues to achieve the goal of a standardized method for monitoring compliance with the 25% QP requirement.

Suspension of Enrollment for Community Support Services

On November 8, 2007, Dempsey E. Benton, Secretary of the Department of Health and Human Services, suspended enrollment and expansion of sites for community support child and adult services. The suspension was created to allow time to implement initiatives that would assure recipients of Community Support Services are receiving high quality services. As of this date, not all steps have been completed, thus the suspension and guidelines outlined in the November 8, 2007 memorandum will remain in effect until further notice.

Service Definition Review Workgroup Update

The workgroup convened by the Division of Medical Assistance (DMA) and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services consisting of consumers and family members, providers, LME representatives, as well as representatives from both Divisions continues to meet two days a week to review the enhanced service definitions. The workgroup has completed their review of Community Support - Child, Community Support - Adult, Community Support Team, and Assertive Community Treatment Team service definitions. The workgroup is beginning the substance abuse service definitions of Substance Abuse Intensive Outpatient and Comprehensive Outpatient services (SAIOP & SACOT). Questions or comments can be sent to the workgroup chairperson, Bert Bennett at Bert.Bennett@ncmail.net.

CAP-MR/DD Waivers Development Update

We are in process of finalizing the specific components of the two waiver applications in preparation for submission to Centers for Medicare and Medicaid Services (CMS) on August 1, 2008. The service definitions have been reviewed and revised per the Physicians' Advisory Group (PAG) and are in the process of being posted on the DMA and DMH/DD/SAS websites. Once posted the public may review and provide comments to DHHS.

Person Centered Plan Form Change for Court Involved Consumers under Age 21

Effective August 1, 2008 for consumers who are less then 21 years of age and who are actively involved with the Department of Juvenile Justice or the adult criminal court system, service requests must include an attestation on the Person Centered Plan (PCP) signature page that the provider has (a) met with the child and family team, and, (b) conferred with the clinical staff of the applicable LME, to conduct intensive care management, care coordination, or inter-agency care coordination. A check box for the attestation will be added to the downloadable PCP form at www.dhhs.state.nc.us/mhddsas. Providers may submit with the request any additional information resulting from such meetings that will inform the determination of medical necessity. Applicable requests lacking such attestation where a reference to court involvement is otherwise evident in the request documentation will be returned to the provider as incomplete requests.

As a reminder, providers may send to ValueOptions any additional information to support or further explain the request of services. The ITR and PCP are the minimal required information. Assessments, notes from team meetings, clinical recommendations or other documentation that supports the clinical recommendation may be submitted.

Staffing Announcements from DMA

DMA has several staffing changes to announce:

Program Integrity:
The Program Integrity section is responsible for Provider Medical Review, Home Care Review, Pharmacy Review, Provider Administrative Review, Third-Party Recovery Section (TPR), Quality Assurance, and Special Projects Section. The team leaders that mh/dd/sa providers will deal with the most are Pat Delbridge with the Provider Administrative Review Section and Carleen Massey in the Provider Medical Review Section. The main number for Program Integrity is 919-647-8000.

Clarence Ervin is the Assistant Director for Program Integrity. Clarence graduated from Saint Leo University in 1983 with a BA in Business Administration. He began his career with Medicaid in 1992 as the APA coordinator. In 1994 he assumed the position of Chief of the Provider Administrative Review Section of Program Integrity. In 1998 he assumed the position of Chief of Practitioner and Clinical Services within the Clinical Policy Unit of Medicaid. Clarence completed a MHA from Pfeiffer University, in December 2003. Clarence left DMA for a short time and rejoined DMA in April of 2008 as the Assistant Director of Program Integrity.

Clinical Services:
The Clinical Policies and Programs section is responsible for the overall administration of programs and clinical services covered in the North Carolina Medicaid Program which includes Clinical Coverage Policies and Manuals, Proposed Medicaid Clinical Coverage Policies, Dental Program, and the Outpatient Pharmacy Program. The main number for Clinical Policy is 919-855-4260.

Dr. Patti Forest is the Acting Assistant Director for Clinical Services effective June 1st and the Medical Director. Dr. Forest graduated from the University of Tennessee College of Medicine in 1991 and completed her residency training in Family Medicine at Naval Hospital in Pensacola Florida in 1994. She has held positions as Program Director of St Luke's Hospital Family Medicine Residency, Medical Director of St Luke's Family Practice and Co-Director of Quality for St Luke's Hospital and Health Network. She completed a fellowship through the National Institute for Program Director Development in 2001 and a Physician Executive MBA at University of Tennessee in 2006. Dr. Forest joined DMA as Medical Director in January 2007.

Catharine Goldsmith joins DMA as the Chief of the Behavioral Health Section within Clinical Policy. Catharine is a LCSW and joined DMA June 16th. Catharine is returning to North Carolina from Florida where she was Program Administrator with the Behavioral Health Unit at Florida Medicaid. Prior to going to Florida, Catharine was a practicing clinician at Dix Hospital and in the community through "the old area authorities."

Reporting Provider Changes
All providers are responsible for ensuring that information on file with the N.C. Medicaid program for their practice or facility remains up to date. This includes changes of ownership (within 30 days), name, address, telephone number, electronic mail address, tax identification number, licensure status, and the addition or deletion of group members.

Providers shall complete and return the Medicaid Provider Change Form to report changes in provider status. The form is also available on DMA's web site at http://www.ncdhhs.gov/dma/forms.html (under Provider Forms, then Administrative). Failure to report changes in provider status may result in suspension of the Medicaid provider number and a delay in provider's receipt of claims reimbursement. In addition, providers may be liable for taxes on income not received by their business.

If Remittance Advices (RAs) and checks cannot be delivered due to an incorrect billing address in the provider's file, all claims for the provider number are suspended and the subsequent RAs and checks are no longer printed. Automatic deposits are also discontinued. Once a suspension has been placed on the provider number, the provider has 90 days to submit an address change. After 90 days, if the address has not been corrected, suspended claims will be denied and the provider number will be terminated.

Common Billing Errors
The Division of Medical Assistance has been working with Electronic Data Systems (EDS) to review provider billing practices to identify repeated errors on provider claims that prohibit payment. There remain a large number of errors being submitted on claims that are the provider's responsibility to ensure accuracy and completeness.

In Implementation Update #37, a review of common billing errors was provided. At that point in time, errors were identified affecting 30% of all claims for a sampled one week period. A current review of claims paid for a recent one week period, resulted in approximately 20% of claims denied. The reasons for these errors included:

- The procedure code on the claim does not match the procedure code on the authorization
- The timeframe for authorization does not match the dates of service billed on the claim
- The provider number authorized does not match the attending provider number billed on the claim

These errors were from 270 unique provider sites, representing 211 provider corporations.

It is incumbent upon each provider to ensure the accuracy of authorization requests and billing for approved services. As referenced in the Medicaid Participation Agreement, "DMA may withhold payment because of irregularity from whatever

cause until such irregularity or difference can be resolved or may recover overpayments, penalties or invalid payments due to error of the provider and/or DMA and its agents."

Any questions concerning claim denials should be directed to EDS Provider Services.

New Denial Code on Explanation of Benefits

Providers will see a new Explanation of Benefits (EOB) denial code effective with July check writes. The code is as follows:

- EOB 4025 - Related Enhanced Benefit Services not allowed same day

Completion of Notification of Endorsement Action Forms

In order for the Division of Medical Assistance to process Notification of Endorsement Action letters effectively, the Local Management Entity must ensure the NEA letters are completed accurately as follows:

- Include provider agency name
- Include provider Medicaid number
- Include only one Medicaid number and service per NEA
- The site address on the NEA must match the provider's site address
- The NEA must be signed
- Only use the standardized template(see Appendix A); this form will be posted on http://www.ncdhhs.gov/mhddsas/stateplanimplementation/providerendorse/index.htm as part of Implementation Update #45
- Only send a NEA withdrawing endorsement to the DMA email address at endorsement.dma@ncmail.net, or by certified mail to DMA Provider Services at 801 Ruggles Drive, Raleigh, NC 27603

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@ncmail.net.

cc: Secretary Dempsey Benton
Dan Stewart
DMH/DD/SAS Executive Leadership Team
DMA Deputy and Assistant Directors
Christina Carter
Sharnese Ransome
Kaye Holder
Wayne Williams
Shawn Parker
Andrea Poole
Mark Van Sciver
Brad Deen

Appendix A

Notification of Endorsement Action

☐ Initial
☐ Additional (service)
☐ Change

Enter Date

Enter LME Name
Enter Street Address
Enter City, State, Zip

Enter Provider Name
Enter Street Address
Enter City, State, Zip

Provider Federal ID #:
Provider NPI #:
Provider Medicaid #:

Dear Enter Provider Name,

Your organization has been reviewed by Enter LME Name with the following results for the location and service indicated.

Name of the LME that Granted Business Verification: _____
Provider Business Name: _____
Provider Contact Person: _____
Business Mailing Address: _____
Business Phone: _____
Physical Site Address (specify provider name if different than above): _____
County: _____
Service Type(s): _____

STATUS	EFFECTIVE DATE
☐ Business Verification	mm/dd/yy
☐ Endorsement	mm/dd/yy to mm/dd/yy
☐ Endorsement Pending	
☐ Due to Referral to DHSR (Date Pended)	mm/dd/yy
☐ Other (see comments)	
☐ Denial of Endorsement (see comments)	mm/dd/yy
☐ Withdrawal of Endorsement	
☐ Voluntary	mm/dd/yy
☐ Involuntary *	mm/dd/yy
Type of Withdrawal	
☐ Business Withdrawal	mm/dd/yy
☐ Enhanced Service(s) Withdrawal**	mm/dd/yy
☐ CAP-MR/DD services withdrawal	mm/dd/yy
Notification Sent Statewide ☐ Yes ☐ No	mm/dd/yy

SUBSTANCE ABUSE SERVICES (if applicable)

☐ SAIOP:

License type***
- ☐ .3700 and waiver; or
- ☐ .3700 and schedule of 12 hours/week or more; or
- ☐ .4400

☐ SACOT:

License type***
- ☐ .3700 and waiver; or
- ☐ .4500

Additional Comments (include reason for denial or withdrawal if applicable): _____

Sincerely,

_____ (LME Designee)
Signature

Printed Name , Job Title

cc: DMH/DD/SAS (endorsements.accountability@ncmail.net)

* Involuntary Withdrawal of Endorsement **must** be signed by the Endorsing Agency CEO (LME Director).
** Under additional comments section, list each service to be withdrawn including: corresponding site specific address and Medicaid Number and primary reason for withdrawal.
*** Attach copies of SA Licenses and or Waiver letters.